

MONTGOMERY COUNTY

EMPLOYEE LIFE INSURANCE & RETIREMENT BENEFICIARY FORM

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.	DEPT. NAME
— —				

Designation of Life Insurance Beneficiaries

Unless otherwise provided, where two or more beneficiaries are named, payment will be made in equal shares to the named beneficiaries who survive the Insured. If no beneficiary survives the Insured, payment will be made in accordance with the terms of the policy. (Please fill out each section completely.)

PRIMARY INSURANCE BENEFICIARY

NAME	RELATIONSHIP	ADDRESS

CONTINGENT (To receive benefits if the primary beneficiary DOES NOT survive the insured)

NAME	RELATIONSHIP	ADDRESS

Employee Signature _____

Date _____

Designation of Retirement Plan Beneficiaries

Part-time permanent employees may elect or decline membership in the retirement system.

As a part-time employee, do you wish to have retirement contributions taken? ☐ YES ☐ NO

PRIMARY RETIREMENT BENEFICIARY

NAME	RELATIONSHIP	ADDRESS

CONTINGENT (To receive benefits if the primary beneficiary DOES NOT survive the insured)

NAME	RELATIONSHIP	ADDRESS

Employee Signature _____

Date _____

Signature and Address of Witness _____

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RETIREMENT CODE: _____ HR SPECIALIST NAME: _____ DATE: _____